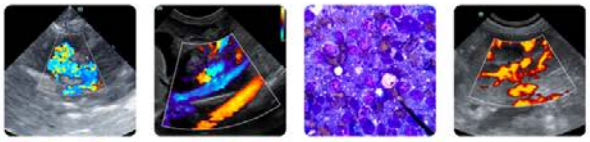


PATIENT

Tuffy Shellhammer

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

15 Years

WEIGHT

5.23 kg

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Dr. Abby Gerenser

HOSPITAL NAME

Abby Road Veterinary Hospital

REFERRING VET

Dr. Abby Gerenser

INVOICE

74314

DATE

4/8/26

PRESENTING CLINICAL SIGNS

Patient is diabetic and hyperthyroid. Has been managed on Lantus insulin and methimazole. Has been steadily losing weight for the past year. Was recently hospitalized after falling off his cat tree. His owner had put his food down, given him his insulin, walked away and heard a thud and found him at the base of the cat tree. Patient was hypoglycemic on presentation. Was given IV dextrose and fed and glucose stabilized. Face suddenly swelled and was given diphenhydramine, which seemed to help. Patient seemed painful in neck/jaw area. Was admitted following day for BG curve, which was normal.

Abnormal PE/Chem/CBC/UA Results: Mild ALT elevation, elevated pLI ProBNP pending

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney is normal in size (4.17 cm) but slightly irregular in shape. Overall echogenicity is slightly hyperechoic with mildly reduced corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (4.21 cm) but slightly irregular in shape. Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The region of left adrenal (Cranial to left renal artery) is unremarkable but the adrenal is not distinctly visualized. No evidence of a mass effect is visualized.

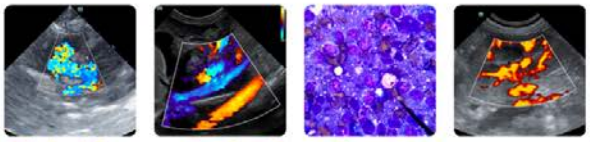
The right adrenal gland is normal in size measuring 0.42 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size (0.97 cm), echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

Liver

The liver is large with smooth peripheral margins. The parenchyma is hyperechoic and homogenous in echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.



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The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and likely incidental at this time. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains mild/moderate fluid/ingesta. It measures at a normal thickness of <0.36cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal fluid distension. Wall thickness is normal to slightly increased. Bowel loops follow a typical curvilinear path with distinct wall layering, but some areas display a prominent muscularis layer which does not display the typical 1:3 muscularis:mucosa layer ratio. Duodenum wall measures 0.20 cm. Jejunum wall measures 0.25 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The pancreas is large, prominent and hypoechoic with prominent pancreatic duct. There is no evidence of nodules or cystic lesions. There is mild/moderate mesenteric inflammation in the right cranial abdomen in the region of the body of the pancreas.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Age related changes visualized associated with both kidneys.
- Pancreatic changes most consistent with chronic active pancreatitis.
- Large, hyperechoic liver – Hepatic changes are non-specific and could be consistent with hepatic lipidosis, inflammatory/infectious disease, infiltrative neoplasia, or other hepatopathy.
- Prominent small intestine with some areas exhibiting a mildly prominent muscularis layer – The mild small intestinal wall changes may be a normal variant in this patient or could be consistent with an inflammatory process (e.g., inflammatory bowel disease).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The pancreas appears large, prominent and hypoechoic, particularly in the region of the body with some surrounding reactive mesentery, most consistent with active inflammation/chronic pancreatitis. Correlate with a PLI level and continue empirical treatment for pancreatitis.

The liver is large and hyperechoic. This is a common finding in diabetics (diabetic hepatopathy). If a more

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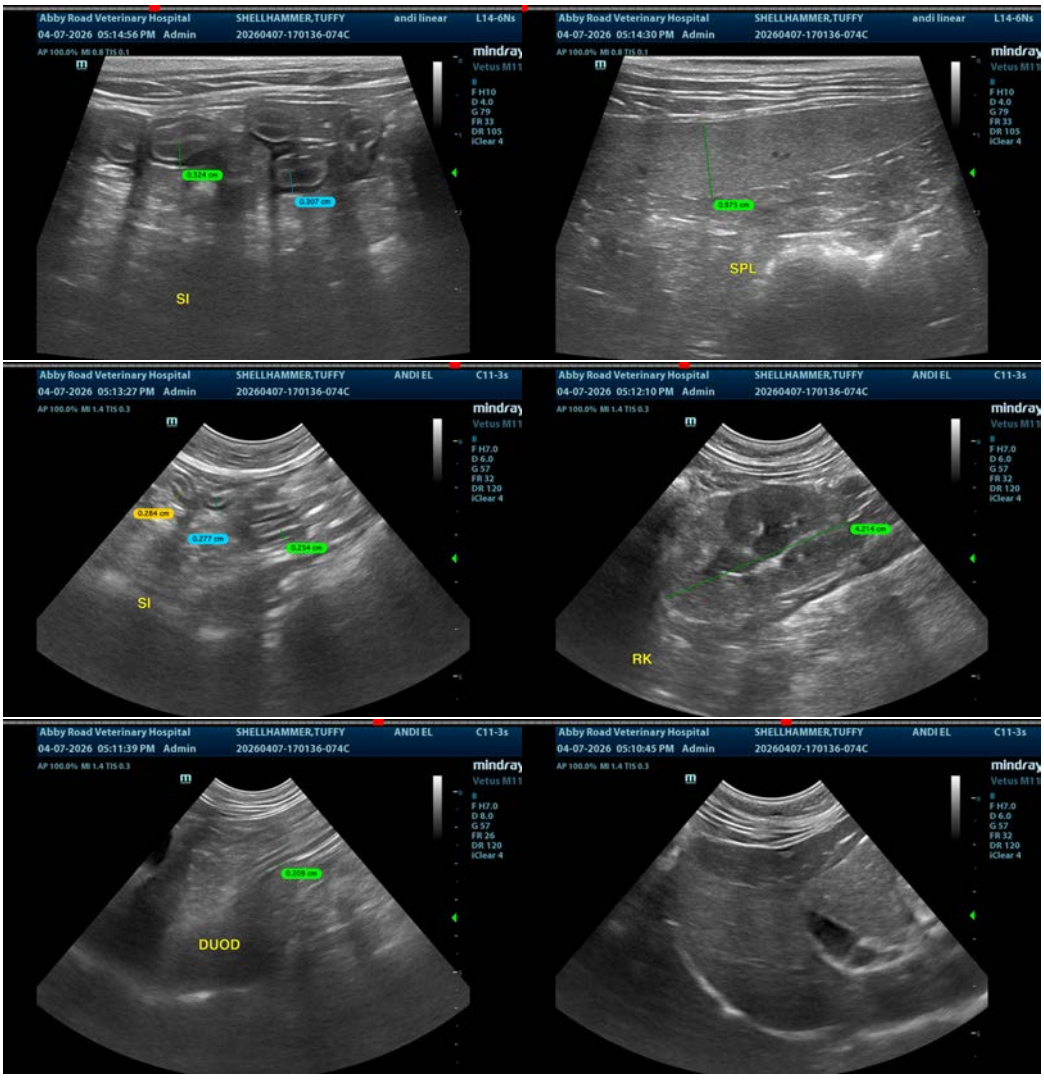
significant hepatopathy is a concern, you could consider a liver function test and a fine needle aspirate of the liver.

The small intestinal changes are mild but there some areas that measure slightly thickened with a prominent but not overtly thickened muscularis layer. You could consider a GI panel to Texas A&M for a qualitative fPLI, TLI, cobalamin and folate, looking for evidence of chronic small intestinal disease and to further evaluate pancreatic values.

If the patient would tolerate a freestyle libre, this could be considered to get a better idea of glycemic control over time. I'm concerned with the hypoglycemic event that there could be periods of time when the blood sugar is dropping too low. A more prolonged curve could help to identify Somogyi effect or similar.



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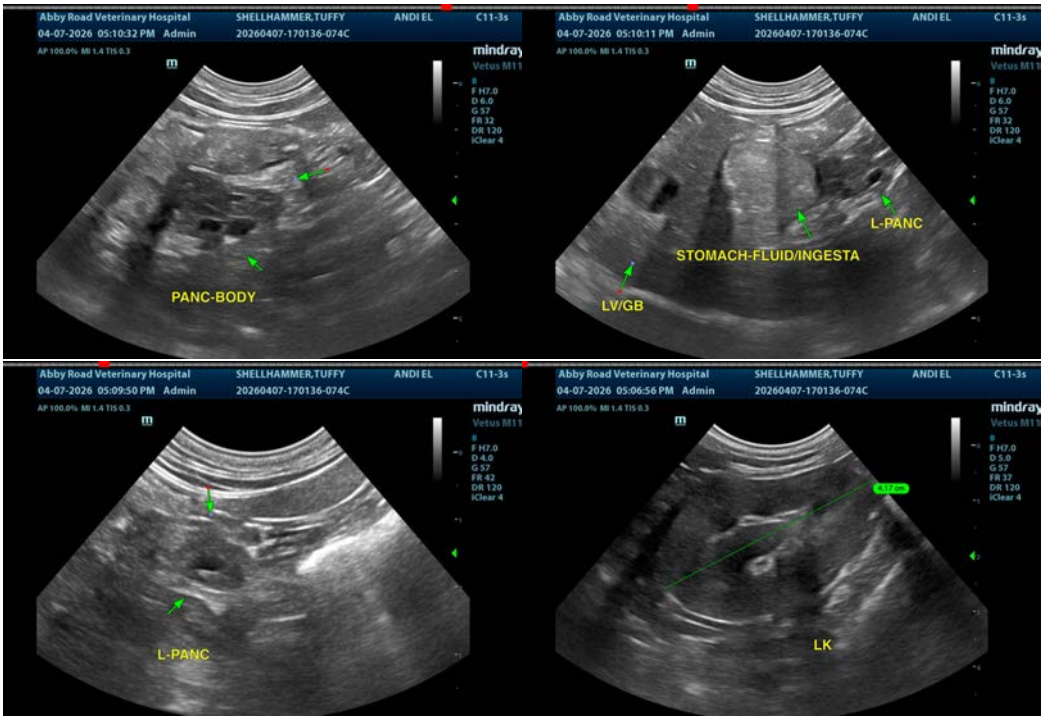

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)

info@sonopath.com